# CLIENT QUESTIONNAIRE

<table>
<thead>
<tr>
<th>Name</th>
<th>Date of Birth</th>
<th>Date of Visit</th>
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**Fill in the circle with your response**

1. **Do you have high cholesterol?**
   - If you answered “No”, skip to question 2.
     - **Do you take medication to lower your cholesterol?**
       - ○ Yes  ○ No  ○ Don’t know/Not sure
     - **During the past 7 days (including today), on how many days did you take prescribed medication to lower your cholesterol?**
       - ○ 1  ○ 2  ○ 3  ○ 4
       - ○ 5  ○ 6  ○ 7  ○ 0 (I didn’t take it)
       - ○ Not applicable

2. **Do you have high blood pressure?**
   - If you answered “No”, skip to question 3.
     - **Do you take medication to lower your blood pressure?**
       - ○ Yes  ○ No  ○ Don’t know/Not sure
     - **During the past 7 days, on how many days did you take prescribed medication (including diuretics/water pills) to lower your blood pressure?**
       - ○ 1  ○ 2  ○ 3  ○ 4
       - ○ 5  ○ 6  ○ 7  ○ 0 (I didn’t take it)
       - ○ Not applicable
     - **Do you measure your blood pressure at home or using other calibrated sources?**
       - ○ Yes  ○ No – I have never been told I had high blood pressure
       - ○ No – I was never told to do it
       - ○ No – I don’t know how to do it
       - ○ No – I don’t have access to the equipment
       - ○ Multiple times per day  ○ Daily
       - ○ A few times per week  ○ Weekly  ○ Monthly
       - ○ Other
       - ○ Not Applicable
     - **How often do you measure your blood pressure at home or using other calibrated sources?**
       - ○ Yes  ○ No  ○ Don’t know/Not sure
     - **Do you regularly share blood pressure reading with a health care provider for feedback?**
       - ○ Yes  ○ No  ○ Don’t know/Not sure

3. **Do you have diabetes/ blood sugar (either Type 1 or Type 2)**
   - If you answered “No”, skip to question 4.
     - **Do you take medication to lower your blood sugar (for diabetes)?**
       - ○ Yes  ○ No  ○ Don’t know/Not sure
     - **During the past 7 days, on how many days did you take prescribed medication to lower blood sugar (for diabetes)?**
       - ○ 1  ○ 2  ○ 3  ○ 4
       - ○ 5  ○ 6  ○ 7  ○ 0 (I didn’t take it)
       - ○ Not applicable
4. Have you been diagnosed by a healthcare provider as having any of these conditions: coronary heart disease/ chest pain, heart attack, heart failure, stroke/transient ischemic attack (TIA), vascular disease, or congenital heart defects?  ○ Yes  ○ No  ○ Don’t know/Not sure

5. How many cups of fruit do you eat in an average day?  ○ None  ○ 1  ○ 2  ○ 3  ○ 4  ○ 5  ○ 6 or more ________
   (1 cup serving is roughly the same as: 1 large orange or banana, 1 small apple, wedge of melon, 8 strawberries, 15 grapes, ½ cup raisins)

6. How many cups of vegetables do you eat in an average day?  ○ None  ○ 1  ○ 2  ○ 3  ○ 4  ○ 5  ○ 6 or more ________
   (1 cup serving is roughly the same as: 12 baby carrots, 2 large stalks of celery, 2 cups lettuce, 1 ear of corn, 1 medium potato, 1 cup cooked greens)

7. How many servings of fish do you eat weekly?  ○ 1  ○ 2  ○ 3  ○ None
   1 serving is 3.5 ounces (approximately the same size as a deck of cards)

8. How many servings of whole grains do you eat daily?  ○ 1  ○ 2  ○ 3  ○ 4  ○ 5  ○ 6 or more ________
   1 serving equals 1 slice whole wheat bread, 1 cup whole grain cold cereal, ½ cup oatmeal/ whole wheat pasta/ brown rice, 3 cups popped popcorn

9. How many ounces of beverages with added sugars weekly?  ____________Ounces  ○ None
   (non-diet soda, sugar sweetened ice tea, fruit punch, …)
   1 CAN is 12 ounces, 1 Bottle is typically 20 ounces.
   1 can every day = 84 ounces weekly; 1 bottle every day = 140 oz. weekly

10. Are you currently watching or reducing your sodium or salt intake?  ○ Yes  ○ No

11. How many minutes of moderate physical activity do you get in a week?  _________________ Number of minutes
    (can usually talk, but not sing during the activity, like brisk walking)

11b How many minutes of vigorous physical activity do you get in a week?  _________________ Number of minutes
    (cannot say more than a few words without pausing for a breath, like running)
    ○ No  ○ Don’t know/Not sure

12a. Do you smoke? Includes cigarettes, pipes, or cigars  ○ Current smoker  ○ Quit (1-12 months ago)
    (smoked tobacco in any form)  ○ Quit (>12 months ago)  ○ Never smoked

12b. About how many hours a day, on average, are you in the same room or vehicle with another person who is smoking?  _________________ Number of hours  ○ None

13. Thinking about your health in the last 30 Days:
   a. How many days was your physical health not good?  _________________ Number Days (no more than 30)
      (including illness and injury)
   b. How many days was your mental health not good?  _________________ Number Days (no more than 30)
      (including stress, depression, and problems with emotions)
   c. How many days did poor physical or mental health keep you from doing your usual activities, such as self-care, work, or recreation?  _________________ Number of Days (no more than 30)